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FISCAL IMPACT STATEMENT

LS 6877
BILL NUMBER: HB 1269

NOTE PREPARED: Jan 26, 2015
BILL AMENDED:

SUBJECT: Mental Health Matters.

FIRST AUTHOR: Rep. Clere
FIRST SPONSOR:

BILL STATUS: As Introduced

FUNDS AFFECTED: X **GENERAL**
DEDICATED
X **FEDERAL**

IMPACT: State & Local

Summary of Legislation: This bill has the following provisions:

Offender's Authorized Representative: It makes the Department of Correction (DOC) an inmate's authorized representative for applying for Medicaid for inmates who are potentially eligible for Medicaid and who incur medical care expenses that are not otherwise reimbursable.

It makes the sheriff who is responsible for a county jail an offender's authorized representative for applying for Medicaid for offenders held in county jails who are eligible for Medicaid and who incur medical care expenses that are not otherwise reimbursable.

Assistance with Medicaid and Treatment: The bill provides that the DOC shall assist a committed offender in applying for Medicaid and securing treatment upon discharge from the DOC, and it provides that a sheriff shall assist an offender in applying for Medicaid and securing treatment upon discharge from a county jail.

It provides that a community mental health center may be used in assisting with DOC inmates and county jail offenders applying for Medicaid.

Evaluation and Treatment Plan: The bill requires that after a person is arrested and taken into custody, a mental health or addiction professional shall assess the person and report the recommended treatment plan to the person and to the law enforcement agency that arrested the person if the person is determined to have a mental health issue or substance abuse addiction.

Amendments and Waivers: The bill requires the Office of Medicaid Policy and Planning to apply, before January 1, 2016, to the United States Department of Health and Human Services for the following Medicaid plan amendments or demonstration waivers:

(1) Presumptive eligibility for community mental health centers to treat individuals seeking treatment for health services at the community mental health center.

(2) Provision of behavioral health homes within the Medicaid program.

Medicaid Claims Filing for Community Mental Health Centers: It allows a community mental health center to use the center's provider identification number to file any Medicaid claim, including primary care health service, if certain conditions are met, and it prohibits the Office from limiting the filing by a community mental health center of primary care health services and mental health services for a recipient if the services are covered services and necessary to ensure coordinated care for the recipient.

Mental Health First-Aid Training Program: The bill requires the Division of Mental Health and Addiction (DMHA) before June 30, 2016, to develop a Mental Health First-Aid Training Program. It includes a mental health first-aid training program in the:

(1) continuing education programs promoted by the Emergency Medical Services Commission (Commission);

(2) basic or in-service course of education and training for teaching professionals; and

(3) requirements for an initial teaching license.

School Counselors: It authorizes the DMHA to award matching grants to a school corporation necessary for a school counselor to obtain a mental health counselor license. The bill provides that the funding for the grants shall be provided by the Indiana Secured School Fund.

School Corporations: The bill requires, before July 1, 2016, a school corporation to enter into a memorandum of understanding with a mental health care provider or a community mental health center to establish conditions or terms for referring students of the school corporation for services.

Appropriation: It annually appropriates $22 M to the Forensic Diversion Program Account, and provides that the account is established to administer and fund mental health and substance abuse assessments of individuals arrested and taken into custody.

Effective Date: July 1, 2015.

Explanation of State Expenditures: *Summary:* The bill will increase appropriations from the state General Fund by $22 M, but may result in cost savings of $1.6 M of state General Fund monies.

It also makes a $600,000 transfer from the Indiana Secured School Fund to make matching grants and may increase expenditures for the DMHA.

The state share of Medicaid services costs for former DOC inmates may increase if the DOC submits the Medicaid application so that the prisoner is eligible for Medicaid upon release and more former prisoners use Medicaid services. The extent that the DOC's costs for treatment of prisoners with mental health and substance abuse addiction decrease is indeterminate.

Additional Information -

General State Prisoner Information: On average between 2011 and 2013, there were 13,271 offenders released on parole, discharged, or sent to community transition programs. An estimated 17% of the general prison population has a mental health diagnosis, and between 80% and 85% have a significant substance abuse history. Based on the proportion of mental illness and substance abuse addiction, it is estimated that about 2,256 prisoners leaving a state facility have a mental health diagnosis and that at least 10,616 have substance abuse history. [The number of dually diagnosed individuals is unknown, but adding these two populations is not appropriate.]

Offender Release: The bill will have indeterminate increased costs for the DOC to assist committed offenders to apply for Medicaid and secure mental health and substance abuse treatment upon release. However, administrative expenditures, with certain exceptions, may be matched at the federal rate of 50%, reducing the state's share of costs.

DOC Services: The DOC assesses prisoners entering state facilities and may create a treatment plan based on the assessment. If a treatment plan were to come with a prisoner from a county jail, it would be considered depending on the resources needed to carry it out. It is unclear what would happen if the DOC plan differs from the treatment plan established at the jail.

Offender's Authorized Representative: No data has been made available to allow an estimate of the level of savings that might accrue to the Indiana DOC. The experience of other states indicates that under current Medicaid eligibility, the DOC might expect to bill about $2.5 M annually to Medicaid. This would result in federal reimbursement of about $1.6 M per year.

This bill may increase the amount of Medicaid reimbursement that may be claimed due to inpatient admissions of eligible inmates in medical care facilities by authorizing the DOC to apply for Medicaid eligibility in those instances where an inmate is unable or unwilling to authorize the Medicaid application. Currently, inmates who require inpatient medical care and are otherwise eligible for Medicaid may be enrolled in Medicaid in order to allow the facility and other health care providers that provide inpatient services to bill the Medicaid program rather than DOC. This allows DOC to leverage the Medicaid federal financial participation of 66.5%, rather than using 100% state dollars to pay for the inmate's inpatient care.

The Indiana Medicaid program and DOC began implementation of this program on December 19, 2014. It is too soon to have data to indicate the level of savings that might be realized. The amount of savings to be realized will depend on the number and length of qualifying inpatient stays provided off site, the amount currently being spent for qualified inpatient admissions, and when the Centers for Medicare and Medicaid Services (CMS) might approve the current HIP 2.0 Medicaid expansion.

Current statute [IC 11-10-3-6] requires the DOC or a county to reimburse a hospital, physician, or another health care provider at the federal Medicare rate plus 4%. If there is no Medicare rate for the health care service provided, the reimbursement is set at 65% of the hospital charge description master or the physician's or other health care provider's charge. Medicaid hospital inpatient reimbursement is currently aligned with Medicare rates, while physician services for State Plan services are reimbursed at approximately 60%. Currently, billing inpatient hospital, physician, and other health care providers through Medicaid would result in a savings simply due to the fact that Medicaid payments will not include the 4% add on for hospital payments or the approximately 5% increase for physician and other health care provider payments. It is not clear how the additional required amounts will be paid to the providers. The DOC and counties taking part

in the program would be expected to reimburse Medicaid the 33.5% state Medicaid match for any qualified billings.

Savings under Medicaid Expansion: Current Indiana Medicaid eligibility is not generally available to nondisabled adults without dependent children. If the Healthy Indiana Plan (HIP 2.0) Medicaid expansion waiver is approved, adults under the age of 65 with income below 138% of the federal poverty level would become eligible for Medicaid. The savings potential of billing Medicaid for qualified inpatient stays would be magnified after a Medicaid expansion. This is particularly the case since the expansion population is eligible for enhanced federal participation. (The state of Michigan has estimated that up to 80% of prisoners and parolees would become eligible for Medicaid.) There are no data at this time to indicate the current cost of inpatient care for the Indiana DOC. An estimate on potential savings to the DOC under a Medicaid expansion will be added if information is made available.

The incarcerated expansion population would not fit into the managed care HIP 2.0 model. Inmates would be covered on a fee-for-service basis for a range of covered inpatient services. It is not clear if the state would need a waiver or a state plan amendment to add this program alongside the HIP 2.0 expansion waiver.

Currently, the Medicaid Act provides an exception to the inmate prohibition for federal matching funds when a resident or inmate becomes an inpatient in a medical institution such as a hospital or nursing facility that is not under the control of the state's correctional system. (This exception also applies to patients of state-run institutions for the developmentally disabled and the mentally ill.) CMS has clarified that federal matching funds would be available when a resident or inmate is admitted as an inpatient to a hospital, nursing facility, juvenile psychiatric facility, or ICF-MR for at least 24 hours, provided that they are eligible for or meet eligibility criteria for Medicaid such as income eligibility or level-of-care requirements for long-term care.

The inmate exception could result in some savings with regard to inmates or residents that are currently eligible for Medicaid who require inpatient services. An example would be inpatient labor and delivery services for pregnant women or inpatient services for an aged, blind, or disabled inmate who cannot be provided within the secure facility. Additionally, medical services provided for inmates' infants that are boarded in the facility should be an allowable service. Current statute (IC 11-10-3-7) requires DOC to determine if an inmate requiring medical services has insurance or may be covered by Medicaid. The extent to which this determination is made, especially in the counties, is not known. The DOC and Medicaid just started the implementation of eligibility determination as of December 19, 2014.

Presumptive Eligibility: The bill requires FSSA to apply for a Medicaid State Plan amendment (SPA) to authorize CMHCs to determine presumptive eligibility for individuals seeking treatment for services at the CMHC. The fiscal impact of this provision would depend on when the Secretary of FSSA would file the SPA and the length of time the Centers for Medicare and Medicaid Services would take to approve the SPA.

Presumptive eligibility is a Medicaid enrollment strategy that states may use to facilitate the enrollment of individuals who are likely eligible for Medicaid or CHIP in order to allow them to access services without having to wait for the full application to be processed. States may authorize qualified entities - health care providers, community-based organizations, hospitals, and schools, among others to screen for Medicaid and CHIP eligibility and immediately enroll eligible individuals and to temporarily provide them with services. Individuals must also submit an application and be determined to be Medicaid-eligible to continue to receive services after the period of presumptive eligibility expires; an individual may receive a presumptive eligibility determination only once during a year. Currently, Indiana Medicaid has presumptive eligibility for pregnant women and as authorized by the Affordable Care Act, hospitals may determine presumptive

eligibility.

Mental Health First-Aid Training Program: The DMHA, in consultation with the Department of Education, the Law Enforcement Training Board, the Indiana Council of CMHCs, the Mental Health America - Indiana, and the Indiana Emergency Medical Services Commission are to develop the program, as required by the bill. The bill would allow the DMHA, the Department of Education, and the Commission to seek federal and state funding to administer and provide the program, which could reduce the total resources needed to fund the program.

The Commission is required by law to promote programs for the training of persons providing emergency medical services and programs for general public education. The bill would require the Commission to promote the proposed program in conjunction with the other programs it currently promotes. This provision should be accomplished within the Commission's existing level of resources.

The DMHA has been involved to some extent with a private provider that offered a one-day training program on youth mental health first-aid on April 4, 2014, in Evansville, Indiana. Cost per person was listed at $50. Although, the fee was waived to applicants. Also, at least four other states have proposed or appropriated specified funds for the development of mental health first-aid training programs. The following table shows the states and the funds either appropriated or proposed.

State	Funding Amount	Target	Status of Legislation
Florida	$300,000	Schools, First Responders	Failed
Minnesota	$45,000	Educators, social services, and law enforcement	Failed
Washington	$100,000	Educators	Failed
Nebraska	$100,000	General	Passed in LB901-2014

School Counselors: Under the bill, the Department of Homeland Security (DHS) would authorize the DMHA to receive from the Indiana Secured School Fund (ISSF) an amount up to $600,000 per state fiscal year for school mental health counselor training. The DMHA would adopt any necessary rules for implementation of the grant program as a routine administrative function. As of December, 15, 2014, DMHA had seven vacant positions with a salary worth of $248,800.

[As of December 24, 2014, the ISSF balance was approximately $16.4 M, and in FY 2015, $11.8 M has been allotted for expenditure. It is likely if no further allotments occur that the DHS, which administers the ISSF, would be able to make a transfer up to $600,000 to DMHA in FY 2016.]

Behavioral Health Homes: The bill requires the FSSA to apply for a Medicaid State Plan amendment to provide behavioral health homes. The fiscal impact of this provision would depend on when the Secretary of FSSA would file the SPA and the length of time the CMS would take to approve it. Health homes for individuals with chronic conditions, including mental health and substance abuse conditions, have been reported to result in reductions in emergency department use and inpatient hospitalizations that may produce savings in total cost. Savings are reported to, at a minimum, offset the new expenditures for primary care and case management services resulting in cost neutrality and in other instances appear to produce a reduction in total cost per patient. The fiscal impact of this provision would depend on when the Secretary of FSSA would file the SPA and the length of time the CMS would take to approve it.

Explanation of State Revenues: *Behavioral Health Homes:* For the first 8 quarters of a state's health home benefit, the FMAP for health home-related service payments will be 90%. Additionally state planning grants are authorized by the ACA at the Medicaid administrative matching rate of 50%.

Medicaid Provisions: Medicaid is jointly funded by the state and federal governments. The effective state share of program expenditures is approximately 33.5% for most current services. Current Medicaid medical services are matched by the effective federal match rate (FMAP) in Indiana at approximately 66.5%. Administrative expenditures with certain exceptions are matched at the federal rate of 50%. Under provisions of the ACA, the enhanced FMAP for the expansion population will be:

(1) 100% for CY 2014, 2015, and 2016;
(2) 95% in CY 2017;
(3) 94% in CY 2018;
(4) 93% in CY 2019; and
(5) 90% in CY 2020 and thereafter.

Explanation of Local Expenditures: *Assessment Services:* The bill will significantly increase county jail costs by an indeterminate amount for the county sheriff to develop processes and procedures to have every person who is taken into custody assessed for mental health issues or substance abuse addiction, and to reassess each person who remains in custody every six months. Depending how the state funds from the Forensic Diversion Program Account are allocated, some or all of the costs of developing and implementing the assessments may be reimbursed.

There are 25 CMHCs in Indiana and jails in 91 of the 92 counties. The CMHCs serve multiple counties, but it is unclear if the CMHCs offer services in each of the counties they serve. Some people are booked into jail and leave within hours of arrest (exact numbers and duration are unavailable), so that using a mental health or addiction professional who is associated with a CMHC may require development of systems to provide immediate assessment services in a timely manner. Some of the demand for assessment may be mitigated by the number of people who are rearrested, estimated at about 70% of all arrestees. However, the bill may require that the individual is to be reevaluated each time the person is taken into custody.

The bill requires that a treatment plan that results from the assessment be provided to the person and the arresting authority. It is unclear what obligation the jailer would have to enact the treatment plan, if the jailer is not the arresting authority. The potential treatment cost is indeterminate, but significant, if the jailer has an obligation to implement the treatment plan.

Offender's Authorized Representative: Few if any states have implemented the program to include county sheriffs due to the complexity of the administrative process, although the literature indicates that counties could benefit from this program. Counties with larger populations would be most likely to take advantage of the program, although local hospitals may be reluctant to participate due to the somewhat lower payment rates.

There are insufficient data to estimate local savings, although county sheriffs could achieve savings if they can deal with the complexity of Medicaid eligibility. Under a Medicaid expansion, savings for both state and local entities would be magnified as more low-income adults would become eligible for Medicaid benefits.

Offender Release: There may be a need for added staff to assist county jail inmates to apply for Medicaid to be eligible for the program prior to being released since 87% of county jails currently report being

understaffed. Under the bill, sheriffs may use a CMHC to assist with Medicaid applications, and administrative expenditures associated with assisting inmates to apply for Medicaid may be matched, with certain exceptions, at the federal rate of 50%. The time limitation on custody could require process development to provide assistance so that the offender is able to receive the assistance prior to being released from jail.

Mental Health First-Aid Training Program: Unless schools would need to purchase course materials for education and training, this provision should present a minimal impact on local school expenditures. Any impact on school expenditures would depend on school governing body action. Currently, teachers can take up to three days in a school year for in-service training for certain subjects. One of the subjects is prevention of child suicide and the recognition of signs of suicidal behavior in students. School corporations are required under current law to pay a teacher's per diem salary for their participation in training. The other training subjects include agriculture, teachers' association, visiting model schools, or autism.

School Counselors: Local schools would have to apply for the grants to the DMHA. It is likely that school corporations would be able to apply for the grants as a matter of routine administrative function. Also, school corporations, if they have not already done so, would likely be able to establish memorandums of understanding with a mental health provider or CMHC within the specified time requirement.

Additional Information -

Jail Population: There are 91 county jails in Indiana, Ohio County does not have one. The DOC's *2013 Annual Jail Report* indicates that there were 16,958 inmates in county jails on the date of the survey. The median number of inmates per jail was 109, ranging from 19 in Tipton County to 994 in Marion County.

The jail population is comprised of arrestees, people awaiting trial, and offenders serving a sentence, with the majority, between 62% and 75% of the jail population, awaiting trial. [Nationally, based on Bureau of Justice Statistics reports, 62% of inmates are unconvicted. LSA estimated that 75% of inmates are awaiting trial using 2007 DOC and 2009 Sheriff's Association data.]

The best estimate of the rate of mental health issues in the county jail population is that about a third of the population is prescribed a medication for a mental health issue. The number with substance abuse addiction is similar to the prison population of 80% to 85%. Dually diagnosed information is unavailable.

Jails have high turnover of inmates. The total duration of stay is a year or under postconviction, and often people under arrest are in custody for short periods of time. The Bureau of Justice Statistics reports that the national average for jails with 50 to 99 inmates is a weekly turnover rate of 83.6% and jails with 100 to 249 inmates, a 67.9% weekly turnover rate.

Studies of Jail Diversion Treatment Programs: There are many studies of mental health or substance abuse diversion programs, especially drug courts. These studies indicate that treatment of mentally ill or substance addiction reduces re-arrest or jail days served in the first 12 months after release from jail. However, it has been noted that re-incarceration or rule compliance does not indicate improvement in mental health status or quality of life.

A limitation of many studies is that they generally do not make comparison or estimate cost savings for more than one year. However, a 2007 study found the second year had even higher savings than the first year for

those who stayed in the treatment. On the other hand, another study involving substance abuse treatment known as therapeutic communities, showed a decline in effectiveness in the third year after release.

California's substance use disorder treatment program evaluation pointed out that the program's process occurred in three stages, with the first stage being the assessment and enrollment of offenders. While this is a necessary part of the overall program, it is not the actual treatment. The authors found, as many other studies have, that criminal history is the best indicator of future criminal behavior, and that among the factors that improved outcome was a stable housing status.

However, a 2007 study using two sites, one in Washington State and one in Florida, linked Medicaid enrollment at release with reduced recidivism for people with severe mental illness. The results indicated that offenders who were released with enrollment in Medicaid had a 16% reduction in the average number of detentions.

Explanation of Local Revenues: *School Counselors:* The maximum amount of grants, overall, that could be received by schools for the purpose of mental health counselor training and licensing would be $600,000. The amount of revenue received by a school would depend on the determination made by DMHA and the amount of funds transferred from the ISSF by the Department of Homeland Security in a given state fiscal year.

State Agencies Affected: Division of Mental Health and Addiction, DHS, Department of Education, Emergency Medical Services Commission, Law Enforcement Training Board, FSSA, DOC.

Local Agencies Affected: County sheriffs, school corporations.

Information Sources: FSSA; DOC;, Other sources available upon request.

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